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SUPERIOR COURT OF THE STATE OF ARIZONA  
IN AND FOR THE COUNTY OF COCHISE

DEBORAH TREBILCOCK, Personal  
Representative of the ESTATE OF STEPHEN  
TREBILCOCK, on behalf of the ESTATE OF  
STEPHEN TREBILCOCK, deceased; and  
DEBORAH TREBILCOCK, Personal  
Representative, for and on behalf of  
STEPHEN TREBILCOCK'S statutory  
beneficiaries pursuant to A.R.S. § 12-612(A),

Plaintiff,

vs.

LIFE CARE CENTERS OF AMERICA,  
INC., a Tennessee corporation, d/b/a LIFE  
CARE CENTER OF SIERRA VISTA, Matt  
Combe Administrator; and JOHN DOES 1-  
200,

Defendants.

Case No.:

**COMPLAINT**

Civil:

- 1) Negligence
- 2) Vulnerable Adult Abuse/Neglect/  
Exploitation under the Adult  
Protective Services Act (A.R.S. § 46-  
455)
- 3) Wrongful Death

Plaintiff alleges as follows:

**JURISDICTION AND VENUE**

1. This Court has jurisdiction over this matter under a) Ariz. Const. article VI, § 14; b) A.R.S. § 46-455(B); and c) Ariz. R. Civ. P. 4.2(a).

2. Because Defendants have caused events to occur in Cochise County by which the causes of action alleged herein have arisen, proper venue lies with this Court.

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1 Institution Administrators and Adult Care Home Managers. During all relevant times, they  
2 were employed as Administrators of Facility.

3 11. At all relevant times, Matt Combe was and is an Arizona resident.

4 12. John Does 111 through 200 are those persons and/or entities whose conduct  
5 caused the injuries alleged herein to Stephen Trebilcock.

6 13. John Does 1 through 200 are persons and/or entities whose relationships to the  
7 named Defendants, or whose acts or omissions, give rise to legal responsibility for the  
8 damages incurred by Stephen Trebilcock, but whose true identities, at the present time, are  
9 unknown to Plaintiff. These persons are hereby notified of Plaintiff's intention to join them  
10 as defendants if and when additional investigation or discovery reveals the appropriateness  
11 of such joinder. (Hereinafter "Defendants" refers to Facility, Management Defendants, Matt  
12 Combe, and John Does 1 through 200).

13 **DIRECT AND VICARIOUS LIABILITY**

14 14. At all relevant times, Facility and Management Defendants owned, operated,  
15 and/or managed Facility, and furthermore participated in, authorized, and/or directed the  
16 conduct of Facility and its respective agents and employees. Facility and Management  
17 Defendants are therefore directly liable for their own negligence, recklessness, and other  
18 tortious conduct in the hiring and management of their agents and employees, as is more fully  
19 alleged herein.

20 15. At all relevant times, Facility and Management Defendants provided to Facility  
21 management services governing and controlling the nursing care and custodial services  
22 provided to Stephen Trebilcock, and by virtue of their management and control over Facility,  
23 Facility and Management Defendants voluntarily and intentionally assumed responsibility for  
24 and provided supervisory services for the nursing care and custodial services provided to  
25 Stephen Trebilcock while he was a resident at Facility.

26 16. Facility and Management Defendants, through their managers, directors,  
27 presidents, vice-presidents, executive officers, and other agents, directly oversaw, managed,  
28 and/or controlled all aspects of the operation and management of Facility, including budget,

1 staffing, staff training, policy and procedures manual(s), licensing, accounts payable,  
2 accounts receivable, development and leasing, general accounting, cash management, pricing,  
3 reimbursement, capitalization, and profit and loss margins.

4 17. Facility and Management Defendants, through their managers, directors,  
5 presidents, vice-presidents, executive officers, and other agents created budgets, policies and  
6 procedures that Facility employees were required to implement and follow.

7 18. Facility and Management Defendants employed all of those persons who  
8 attended to and provided care to Stephen Trebilcock while he was a resident at Facility, and  
9 employed those persons in management and supervisory positions who directed the  
10 operations of Facility, all of whom were acting within the course and scope of their  
11 employment, during Stephen Trebilcock's residency.

12 19. Facility and Management Defendants, through their administrators, directors,  
13 and managing agents, complied with and ratified all conduct of Facility alleged herein.

14 20. At all relevant times, Facility and Management Defendants were the knowing  
15 agents and/or alter-egos of one another, inclusive, and Facility and Management Defendants'  
16 officers, directors, and managing agents directed, approved, and/or ratified the conduct of  
17 each of the other Facility and Management Defendants' officers, agents and employees, and  
18 are therefore vicariously liable for the acts and/or omissions of their co-defendants, their  
19 agents, and employees, as is more fully herein alleged. Moreover, at all relevant times, all  
20 Facility and Management Defendants were acting within the course and scope of their  
21 employment.

22 21. Defendants' tortious acts and omissions, as alleged herein, were done in concert  
23 with each other and pursuant to a common design and agreement to accomplish a particular  
24 result: maximizing profits by operating Facility in such a manner that Facility was  
25 underfunded and understaffed. Moreover, Facility and Management Defendants aided and  
26 abetted each other in accomplishing the acts and omissions alleged herein.

27 22. Defendants, by their acts and omissions as alleged herein, operated under an  
28 agreement, with a common purpose and community of interest, with an equal right of control,  
and subject to participation in profits and losses, as further alleged herein, such that they



1 operated a joint enterprise or joint venture, subjecting each of them to liability for the acts and  
2 omissions of each other.

3 **FACTUAL SUMMARY/PLAINTIFF'S INJURIES**

4 23. On approximately December 30, 2017, Stephen Trebilcock was admitted as a  
5 resident to Facility and placed under the care of Defendants and their employees. He remained  
6 a resident at Facility until approximately January 11, 2018.

7 24. Defendants knew that Stephen Trebilcock was in a compromised physical and  
8 mental state due to his medical history, which included Type 2 diabetes, asthma,  
9 hypertension, chronic pain, hypothyroidism, cardiac disease, stomach ulcers, severe bilateral  
10 knee arthritis, a left knee replacement, and an insertion of a pacemaker defibrillator.

11 25. As a result of Stephen Trebilcock's condition, he required supervision, close  
12 monitoring, and medical attention to ensure his health, safety, and wellbeing.

13 26. Defendants knew that because of his physical and mental state Stephen  
14 Trebilcock was dependent on them for nursing services.

15 27. Defendants knew that because of Stephen Trebilcock's physical and mental  
16 state he was dependent on them for his activities of daily living.

17 28. Despite Defendants' knowledge of Stephen Trebilcock's risk for skin  
18 breakdown, they failed to properly assess, monitor, and protect him from the development  
19 and worsening of abrasions, sores, and tears, and he in fact suffered the development and  
20 worsening of abrasions, sores, and tears.

21 29. Despite Defendants' knowledge and awareness of his needs, they did not  
22 provide Stephen Trebilcock the attention and care necessary to prevent him from suffering  
23 falls, and he did in fact suffer at least two falls, resulting in blunt force trauma to his head and  
24 Intraparenchymal hemorrhage and ultimately causing his death.

25 30. Despite Defendants' knowledge that Stephen Trebilcock needed assistance with  
26 eating and dietary planning, they failed to provide this assistance, putting Stephen Trebilcock  
27 at risk for malnutrition and hypoglycemia, which conditions he in fact suffered.  
28

1        31. Stephen Trebilcock's injuries were entirely preventable had Defendants simply  
2 provided Facility sufficient staff in number and training to provide him the amount and level  
3 of care that laws and regulations required.

4        32. Stephen Trebilcock's injuries, including death, would not have occurred but for  
5 the complete willful disregard by Defendants of their duties owed to Stephen Trebilcock.

6        33. Stephen Trebilcock was subjected to pain and suffering and eventually died on  
7 January 17, 2018 as a result of the inadequate care and treatment he suffered at Defendants'  
8 hands.

9        **DEFENDANTS' KNOWLEDGE, DUTIES, AND WRONGFUL CONDUCT**

10       34. During Stephen Trebilcock's residency at Facility, Defendants knew or had  
11 reason to know that he was an incapacitated and vulnerable adult under A.R.S. § 46-451.

12       35. At all relevant times, Defendants held themselves out as being competent and  
13 qualified to provide and administer skilled nursing and health care services, including  
14 rehabilitation, to their residents, including Stephen Trebilcock. Further, Defendants held  
15 themselves out as willing to comply with the appropriate standard of care for health care  
16 providers in their respective fields and acted together to provide care as an enterprise as  
17 defined by A.R.S. § 46-455.

18       36. As governing authority for Facility, Facility and Management Defendants were  
19 responsible for the organization and administration of Facility, and had duties including (a)  
20 ensuring that Facility complied with applicable statutes and regulations; (b) adopting policies  
21 and procedures for Facility; and (c) appointing an administrator to manage Facility.

22       37. At all times mentioned herein, Defendants had a duty to employ sufficient  
23 nursing staff to provide nursing and related services to attain or maintain the highest  
24 practicable physical, mental, and psychosocial wellbeing of Stephen Trebilcock, as  
25 determined by appropriately prepared resident assessments and individual plans of care.

26       38. At all times mentioned herein, Defendants had a duty to provide for the safety  
27 of residents, including Stephen Trebilcock, particularly residents who were impaired and in  
28 need of special precautions for their safety, by providing each resident, including Stephen  
Trebilcock, adequate supervision, assistance, nutrition, and nursing and medical intervention

1 to prevent injury or deterioration of health, as well as to provide curative and restorative care  
2 as needed and as prescribed by physicians.

3 39. As Administrators for Facility, Defendants Matt Combe and John Does 101  
4 through 110 had duties including (a) appointing and supervising a medical director to be  
5 responsible for resident medical care at Facility; (b) appointing and supervising a Director of  
6 Nursing for Facility; (c) appointing and supervising a food service supervisor for Facility; (d)  
7 supervising and evaluating staff performance at Facility; (e) developing and implementing  
8 written policies and procedures for nursing services, personnel, staff orientation and in-  
9 service training, admission and discharge of residents, safety and emergency plans, and  
10 quality management plans for Facility; and (f) investigating and reporting all incidents  
11 involving resident neglect or abuse to the Office of Long Term Care Licensure and Adult  
12 Protective Services, if required by A.R.S. § 46-454, and preventing further neglect or abuse  
13 during the course of any investigation.

14 40. Defendants were responsible for providing nursing care to Stephen Trebilcock  
15 while he was a resident at Facility, and owed Stephen Trebilcock a variety of duties under  
16 relevant statutes, regulations, and the common law.

17 41. Among the duties Defendants and their employees owed to Stephen Trebilcock  
18 but failed to perform was the duty to provide reasonable and appropriate health care services  
19 in accordance with recognized standards of care.

20 42. Among the duties Defendants and their employees owed to Stephen Trebilcock  
21 but failed to perform was the duty to provide reasonable care to prevent him from suffering  
22 falls.

23 43. Among the duties Defendants and their employees owed to Stephen Trebilcock  
24 but failed to perform was the duty to provide reasonable care to prevent skin breakdown.

25 44. Among the duties Defendants and their employees owed to Stephen Trebilcock  
26 but failed to perform was the duty to provide appropriate nutritional care.

27 45. Among the duties Defendants and their employees owed to Stephen Trebilcock  
28 but failed to perform were the duties to adequately screen, evaluate, check references of, test  
competence of, and use reasonable care in selecting management, nurses, nursing assistants,

and other personnel to work at Facility.

46. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to employ and train sufficient nurses, nursing assistants, and other personnel to provide adequate care for Stephen Trebilcock.

47. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform were the duties to provide adequate staff to monitor Stephen Trebilcock's condition and to adequately train, motivate, and supervise that staff in performing assessments of his condition and planning for his care and safety needs.

48. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to create and maintain accurate records of Stephen Trebilcock's, condition, progress, and treatment.

49. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to appropriately chart information concerning Stephen Trebilcock's condition, assessments, care planning, history, and monitoring so as to enhance his progress and wellbeing.

50. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to follow orders and recommendations of physicians in providing care and safety management to Stephen Trebilcock.

51. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to notify physicians and emergency services as reasonably necessary to seek a physician's consultation and treatment, and to provide the physicians with adequate information to enable them to make informed decisions concerning Stephen Trebilcock's condition and course of treatment so that appropriate orders could be made for his care and safety.

52. Among the duties Defendants and their employees owed to Stephen Trebilcock but failed to perform was the duty to monitor and properly assess his condition, from initial assessment, ongoing assessment, through the development of a timely care plan and any revisions thereto, and to monitor his general health and safety, nutritional needs, and to report to physicians any failure to improve under the therapies ordered.



1           53.     Stephen Trebilcock's injuries as alleged herein would not have occurred but for  
2 the utter and complete willful disregard by Defendants of their duties to Stephen Trebilcock.

3           54.     Defendants, acting through their agents and employees, failed to properly assess  
4 and diagnose the condition of Stephen Trebilcock, or develop an appropriate care plan to  
5 enhance his health and to address those conditions from which he suffered.

6           55.     Defendants, acting through their agents and employees, failed to adequately  
7 follow physicians' orders concerning Stephen Trebilcock's treatment and failed to properly  
8 monitor and assess his condition and communicate the same to his physician so that  
9 appropriate orders could be taken and later implemented into his plan of care.

10          56.     Defendants allowed Stephen Trebilcock to suffer in a hazardous environment,  
11 and he was therefore forced to suffer poor quality of life.

12          57.     Defendants owed a duty to Stephen Trebilcock, yet failed to provide services  
13 and care needs for his in such a manner and in such an environment as to promote maintenance  
14 or enhancement of his quality of life.

15          58.     Defendants owed a duty to Stephen Trebilcock, yet failed to provide services  
16 and activities and failed to operate, own, manage, control, and/or administer Facility in a  
17 manner enabling him to attain or maintain the highest practicable physical, mental, and  
18 psychosocial wellbeing possible, in accordance with a written plan of care.

19          59.     Defendants owed a duty to Stephen Trebilcock, yet failed to provide services  
20 by sufficient numbers of personnel on a 24-hour basis to provide care to him in accordance  
21 with resident care plans.

22          60.     Defendants owed a duty to Stephen Trebilcock, yet failed to operate and provide  
23 services in compliance with all applicable laws, regulations, and codes, and with accepted  
24 standards and principles that apply to those providing services in a skilled nursing facility.

25          61.     Defendants owed a duty to Stephen Trebilcock, yet failed to ensure that the  
26 nurse's aides or any other staff members providing direct care were able to demonstrate  
27 competency in skills and techniques necessary to care for residents' care needs, including  
28 Stephen Trebilcock's, as identified through residents' assessments and respective plans of  
care.

1           62. Defendants, through Facility administrators, owed a duty to their residents,  
2 including Stephen Trebilcock, yet failed to ensure that Facility's policies and procedures were  
3 established, documented, and implemented that covered abuse of residents, job descriptions,  
4 qualifications, duties, orientation, and in-service education for each staff member, resident  
5 rights, quality management and incident documentation, nursing services, dispensation,  
6 administration, wound management, fall prevention, disposal of medication and biologicals,  
7 infection control, and medical records, including oral, telephonic, and electronic records.

8           63. Defendants breached all of those duties set forth above with respect to Stephen  
9 Trebilcock, a lack of adequate supervision, planning, and training by Defendants in carrying  
10 out their responsibilities to Stephen Trebilcock.

11           64. Defendants' breaches, abuse, and neglect of Stephen Trebilcock also resulted,  
12 in part, from a lack of adequate training of and care by nurses, nurse aides, food service  
13 supervisors, dieticians, and others attending to the care of Stephen Trebilcock at Facility.

14           65. Finally, Defendants' breaches, abuse, and neglect of Stephen Trebilcock, all  
15 with consequential physical and mental suffering, caused Stephen Trebilcock to suffer  
16 injuries at Facility and ultimately caused his death.

17           66. Defendants knew that upon his admission to Facility, Stephen Trebilcock was  
18 in a compromised physical and mental state, as described herein. Further, he was dependent  
19 on Defendants for nursing services.

20           67. Despite Defendants' knowledge of the serious physical, mental, and custodial  
21 needs of Stephen Trebilcock, Defendants intentionally admitted into Facility high acuity  
22 residents, such as Stephen Trebilcock, who required the most intensive care, one reason being  
23 that high acuity residents command a higher rate of income and reimbursement.

24           68. As part of a plan to maximize profits Defendants intentionally cut costs by  
25 failing to adequately train existing or incoming staff to meet the needs of Stephen Trebilcock,  
26 and by retaining incompetent service personnel, many of whom were not properly trained or  
27 qualified to care for him.

28           69. Defendants ratified the conduct of each Defendant in that they mandated, were  
aware of, and/or accepted chronic understaffing and inadequate training at Facility, were

1 aware of Facility's customary practice of receiving complaints and notices of deficiencies  
2 relating to the care of residents, and were aware that such understaffing, inadequate training,  
3 and deficiencies led to injury and death to residents.

4 70. The corporate authorization and enactment alleged herein constituted the  
5 mandate, permission, consent, and ratification of Facility's misconduct by Defendants, who  
6 had within their power, ability, and discretion to mandate that Facility employ adequate staff  
7 in number and training to meet the needs of Stephen Trebilcock.

### 8 **COUNT ONE**

#### 9 **Negligence by All Defendants**

10 71. All allegations in paragraphs 1 through 70 are incorporated by reference.

11 72. Defendants owed Stephen Trebilcock statutory and regulatory standard of care  
12 duties as set forth above.

13 73. Defendants breached those duties.

14 74. Defendants' breaches were the direct, actual, legal, and proximate cause of  
15 Stephen Trebilcock's injuries and death.

16 75. But for Defendants' conduct and breaches of duty Stephen Trebilcock would  
17 not have suffered the injuries described herein.

18 76. The injuries suffered by Stephen Trebilcock were foreseeable as Defendants  
19 knew or should have known that their conduct, which included underfunding and  
20 understaffing Facility, would inevitably lead to the kind of injuries, damages, and ultimately,  
21 death, suffered by Stephen Trebilcock.

22 77. Stephen Trebilcock sustained injuries and damages and ultimately died as a  
23 result of Defendants' breaches.

### 24 **COUNT TWO**

#### 25 **Violation of the Adult Protective Services Act (A.R.S. § 46-455) by All Defendants**

26 78. All allegations in paragraphs 1 through 77 are incorporated by reference.

27 79. At all relevant times, Stephen Trebilcock was unable to make decisions  
28 sufficient to prevent his abuse and neglect.

1           80. At all relevant times, Stephen Trebilcock was unable to protect himself from  
2 the abuse and neglect he suffered at the hands of Defendants before his death.

3           81. Stephen Trebilcock was an incapacitated and vulnerable adult whose life was  
4 endangered by Defendants' conduct, for profit nonetheless, constituting neglect, abuse, and  
5 exploitation as defined in A.R.S. § 46-451(A).

6           82. Stephen Trebilcock employed Defendants to provide him 24-hour care, and  
7 Defendants therefore assumed a legal duty to provide him with proper care.

8           83. Defendants and their employees willfully, intentionally, and/or negligently  
9 caused or permitted Stephen Trebilcock to be injured and/or to be placed in a situation such  
10 that his person or health was in danger, as more fully described above.

11           84. Stephen Trebilcock was deprived of proper nursing and medical services which  
12 led to injuries and harm including skin tears and abrasions, hypoglycemia, malnutrition, and  
13 falls. Such substandard care ultimately resulted in Stephen Trebilcock's death.

14           85. Defendants, by engaging in the conduct alleged herein, made a conscious  
15 decision to promote profits instead of providing the legally mandated care that Stephen  
16 Trebilcock deserved, and as a result Defendants' actions were oppressive, fraudulent,  
17 reckless and/or malicious, i.e., Defendants consciously disregarded the unjustifiable and  
18 substantial risk of significant harm to Stephen Trebilcock's health, safety and welfare.

19           86. The acts and/or omissions of Defendants constitute a breach of the  
20 aforementioned duties and are a deviation from the applicable standard of care in reckless  
21 disregard of the needs of Stephen Trebilcock, constituting abuse and neglect of a vulnerable  
22 adult, giving rise to a cause of action under A.R.S. § 46-455, and justifying an award of  
23 compensatory and exemplary damages, attorneys' fees, and related expenses.

24           87. As a direct, actual, legal, and proximate cause of Defendants' conduct, Stephen  
25 Trebilcock suffered unjustifiable and substantial physical and mental suffering.

26           88. The aforementioned breaches, abuse, and neglect are representative of a pattern  
27 of abuse and neglect of incapacitated and vulnerable adults as evidenced by previous  
28 incidents, lack of appropriate staffing, and ongoing patterns of abuse and/or neglect of  
residents at Facility, including Stephen Trebilcock, thereby justifying investigation by this



1 Court and Deborah Trebilcock into the operations and patterns of abuse and neglect of  
2 residents and other wrongdoing, and justifying an award of damages, both compensatory and  
3 punitive, and such other penalties, injunctions, and orders as the Court deems appropriate.

4 **COUNT THREE**

5 **Wrongful Death by All Defendants**

6 89. All allegations in paragraphs 1 through 88 are incorporated by reference.

7 90. Deborah Trebilcock is the loving wife of Stephen Trebilcock. Stephen  
8 Trebilcock had loving children who survived him.

9 91. As a proximate result of the conduct as more particularly alleged above  
10 perpetrated by Defendants, Stephen Trebilcock died on January 17, 2018.

11 92. Prior to his death, his wife and children enjoyed the love, society, comfort, and  
12 attention of Stephen Trebilcock.

13 93. As a proximate result of the negligent acts of Defendants, which caused the  
14 death of Stephen Trebilcock, his statutory beneficiaries sustained pecuniary loss of the  
15 society, comfort, attention, and love of Stephen Trebilcock in a sum according to proof at  
16 trial.

17 **PRAYER FOR RELIEF**

18 Wherefore, Plaintiff prays for judgment and damages against all Defendants as  
19 follows:

- 20 1. For general damages according to proof;  
21 2. For special damages according to proof;  
22 3. For attorney fees;  
23 4. For punitive and exemplary damages;  
24 5. For costs of suit; and  
25 For such other and further relief as the Court deems just and proper.

1 Dated: September 17, 2019

2 **BOSSIE, REILLY & OH, P.C.**

3  
4 By: /s/ Mary Ellen Reilly

5 Mary Ellen Reilly

6 Melanie L. Bossie

7 Donna Y. Oh

8 *Attorneys for Plaintiff*

9 Copy to be mailed within 30 days to:

10 Mark Brnovich, Attorney General

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28 By: /s/ Renee R. McKinney